Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED					
			A. BUILDING.	VI	R	,				
		HAL017006	B. WING			9/2016				
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE, ZIP CODE							
POOLE'S REST HOME 201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379										
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE				
{C 000}	Initial Comments		{C 000}							
	This report is of a followup survey done by Bob Getchell on January 19, 2016.									
		y revealed that all deficiencies ected, therefore a new plan of ed.								
{C 111}	Must Have Current San. & Fire Safety Reports		{C 111}							
	CONSTRUCTION(f) The facility shall fire and building sat	02 DESIGN AND								
		et as evidenced by: vation, the current fire and vere not available at the time of								
	Followup Findings of The following reportime of the followup a) Sanitation report b) Sanitation report c) Fire Marshalls R	ts were not available at the survey: t for the building, t for the kitchen,								
{C 189}	Building Equipment	t Maintained Safe, Operating	{C 189}							
	mechanical, and plu	11 OTHER Ind all fire safety, electrical, umbing equipment in an adult maintained in a safe and								

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
			A. BUILDING:	U1	F				
		HAL017006	B. WING	 		9/2016			
NAME OF PROVIDER OR SUPPLIER STREET ADI			DDRESS, CITY, STATE, ZIP CODE						
POOLE'S	REST HOME		_	ELOW ROAD					
(X4) ID	YANCEYVILLE, NC 27379 X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)								
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	SHOULD BE COMPLETE				
{C 189}	Continued From page 1		{C 189}						
	(k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.								
	This Rule is not met as evidenced by: 1. Based on observation, the building fire protection equipment was not maintained in a safe manner.								
	Followup Findings on 1-19-16 include: a. The heat detector in room 2 is hanging by the wires. 4. Based on observation, the building exit signage and emergency illumination were not maintained in a safe manner.								
	300 Hall and do not	s are improperly displayed on clearly indicate evacuation ientation. Orient plans to							
	fixtures were not ma	vation, the building plumbing aintained in a safe manner. I residents by exposing them							
	Followup Findings of a. The Mens bathrofrom the floor.	on 1-19-16 include: oom has a toilet coming loose							

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Division of Health Service Regulation STATE FORM